Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SYZGY ASSOCIATES
5601 BRIDGE ST #500
FORT WORTH TX 76112

Respondent Name

EMPLOYERS MUTUAL CASUALTY CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-10-3740-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been denied after reconsideration for the physical performance evaluation. The provider performed this physical performance exam and this was billed out as 97750-GO since this was not a functional capacity evaluation. Employers Mutual Casualty is denying stating that the report is not a physical performance evaluation. These physical exams are very similar, but they are billed out with different modifiers to identify the type of exam that was administered. In this case the exam was a physical performance evaluation."

Amount in Dispute: $260.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This case involves DOS 2/04/10 and has $260.00 in dispute. The carrier denied the original bill, coded 97750-FC because it did not comply with rules concerning the administration of FCEs as it was more than four hours in length. The bill was then resubmitted, coded as 97750-GO, but the original request by the provider was for 'Functional Tasks Tested", not a physical performance exam (GO), which would again be over treatment by a different name."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 04, 2010	97750-GO	$260.00	$260.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203 sets out the Medical Fee Guidelines for Professional Services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 18, 2010
   - 281 – FUNCTIONAL CAPACITY EVALUATIONS ARE ALLOWED A MAXIMUM OF FOUR HOURS FOR AN INITIAL OR THREE TIMES FOR EACH INJURED WORKER.
   - 912 – CHARGES HAVE BEEN REVIEWED AND REDUCED OR DENIED BY OUR NURSE REVIEW UNIT.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

   Explanation of benefits dated March 23, 2010
   - NOTE: DWC Rules Chapter 134 Subchapter C – Medical Fee Guidelines §134.202 Medical Fee Guideline (e) (4) Functional Capacity Evaluations (FCEs). "A maximum of three FCEs for each compensable injury shall be billed and reimbursed."

   Explanation of benefits dated April 5, 2010
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PRECESSED [sic] PROPERLY.
   - 710 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
   - 911 – CHARGES HAVE BEEN REVIEWED BY OUR NURSE REVIEW UNIT.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

Issues

1. Did the requestor bill a physical performance examination or a functional capacity evaluation?
2. Respondent's position statement states that the carrier denied the original billing which was coded as 97750-FC. All billings submitted to MFDR by either party show CPT code 97750-GO. The three EOBs provided show 97750-FC as the CPT/Modifier combination.
3. Is the requestor entitled to reimbursement?

Findings

1. A Physical Performance Evaluation (PPE) is not the same as a Functional Capacity Exam and does not require the FC modifier as required in Texas Administrative Code §134.204(n)(3). A PPE is similar to an FCE, except that it is directed to a particular body area or part. The PPE does not measure activities such as: lifting, carrying, pushing, or pulling. The PPE does provide for a comparison study of ROM of a particular body area. The requestor has billed and documented a PPE, not an FCE.
2. Review of the submitted documentation and billing shows that the Requestor billed 97750-GO per the material available from both parties. On March 15, 2011, DWC requested for information from both requestor and respondent to provide all bills and EOBs for this dispute. No billing was produced from either party that showed an original billing using 97750 with modifier –FC after the opportunity to provide the information. There is no mention of a 97750-FC as the first billing other than the position statement and the coding with –FC modifier on all three EOBS. These show that even though the provider was billing 97750-GO, the carrier was using –FC on the EOBS. The Requestor billed a – GO modifier appropriately as service was performed by an occupational therapist. It does not need an –FC modifier as it is not an FCE. The Requestor cites outdated rules for a previous fee guideline 134.202 and references in denial code 281 a requirement for FCESs, not applicable to a PPE billed. The medical documentation supports that the services billed were rendered.
3. Reimbursement per Texas Administrative Code §134.203(c)(1) is recommended for 8 units for 2 hours with a documented start time of 9:00AM and an end time of 11:00AM in the zip code 75024 for Plano, Collin County, (REST OF TEXAS). The MAR is at $43.47 per unit at $347.73. The Requestor is disputing $260.00, therefore the disputed amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $260.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $260.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 30, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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